HOUSE BILL No. 1860

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15-12-13; IC 12-15-13-2.

Synopsis: Medicaid physician reimbursement rates. Requires the office of Medicaid policy and planning to establish payments to providers based on certain Medicare payment and reimbursement rates. Requires the office of Medicaid policy and planning to adjust payments to providers accordingly, and provides that the adjustment must increase state general fund expenditures by not less than $2,000,000 per year.

Effective: July 1, 2001.

Crawford

January 17, 2001, read first time and referred to Committee on Ways and Means.

Introduced

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

HOUSE BILL No. 1860

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-12-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: **Sec. 13. (a) Except as provided in subsection (b), this section applies to emergency services provided to an individual enrolled in the Medicaid Risk-Based Managed Care program.**

(b) This section does not apply to the following:

(1) Services provided to an individual enrolled in the Medicaid Risk-Based Managed Care program by a provider who has contracted with a Medicaid Risk-Based Managed Care organization to provide emergency services to the individual.

(2) Services provided to an individual after the individual is stabilized medically.

(c) Payment for emergency services (as defined in 42 U.S.C. 1396u-2(b)(2)(B)) provided for the evaluation or stabilization of an emergency medical condition (as defined in 42 U.S.C.

1396u-2(b)(2)(C)) in the emergency department of a hospital licensed under IC 16-21 must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for emergency services.

(d) Payment under subsection (c) is the responsibility of the applicable Medicaid Risk-Based Managed Care organization under 42 U.S.C. 1396u-2(b)(2)(A)(i). This subsection does not prohibit the organization described in this subsection from entering into a subcontract with another Medicaid Risk-Based Managed Care organization providing for the latter organization to assume financial responsibility for making the payments due under subsection (c).

(e) This section does not prohibit a managed care organization's ability to:

(1) review; and

(2) make a determination of;

the medical appropriateness of the services provided in a hospital's emergency department.

SECTION 2. IC 12-15-13-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 2. (a) Except as provided in IC 12-15-14 and IC 12-15-15, payments to Medicaid providers must be:

(1) consistent with efficiency, economy, and quality of care; and

(2) sufficient to enlist enough providers so that care and services are available under Medicaid, at least to the extent that such care and services are available to the general population in the geographic area.

(b) If federal law or regulations specify reimbursement criteria, payment shall be made in compliance with those criteria.

(c) In addition to the requirements under subsection (a), the office shall establish payments to providers listed under 405 IAC 1-11.5-1 (except for oral surgeons and dentists) that are reimbursed through the resource based relative value scale as provided in 405 IAC 1-11.5 under a fee for service program or the Medicaid primary care case management program as follows:

(1) Not less than the most current relative value unit, as established by the federal Health Care Financing Administration, factoring in:

(A) the existing geographic practice cost indices; and

(B) the conversion factor established by 405 IAC 1-11.5-2.

(2) If relative value units are not applicable, the office shall review and adjust the payments as appropriate.

(3) For anesthesia services, the office shall use:

(A) the most current American Society of Anesthesiologists relative value guide's base and modifier units; and

(B) the time unit and the conversion factor established by 405 IAC 1-11.5-2.

(d) The office shall update payment rates at least one (1) time every two (2) years in compliance with this section.

SECTION 3. [EFFECTIVE JULY 1, 2001] **(a) Notwithstanding IC 12-15-13-2, as amended by this act, the office of Medicaid policy and planning shall adjust payments to providers listed under 405 IAC 1-11.5-1 (except for oral surgeons and dentists) that are reimbursed through the resource based relative value scale as provided in 405 IAC 1-11.5 under a fee for service program or the Medicaid primary care case management program. The adjustment described in this SECTION shall increase state general fund expenditures by not less than two million dollars ($2,000,000) annually.**

(b) This SECTION expires June 30, 2002.